Quitting smoking and experience of smoking cessation interventions among UK Bangladeshi and Pakistani adults: the views of community members and health professionals

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Objective: To explore attitudes to quitting smoking and experience of smoking cessation among Bangladeshi and Pakistani ethnic minority communities.

Design: Qualitative study using community participatory methods, purposeful sampling, interviews and focus groups, and a grounded approach to data generation and analysis.


Participants: 53 men and 20 women aged 18–80 years, including smokers, former smokers, and smokers’ relatives, from the Bangladeshi and Pakistani communities; and eight health professionals working with these communities.

Results: Motivation to quit was high but most attempts had failed. “Willpower” was the most common approach to quitting. For some, the holy month of Ramadan was used as an incentive, however few had been successful in quitting. Perceived barriers to success included being tempted by others, everyday stresses, and withdrawal symptoms. Few participants had sought advice from health services, or received cessation aids, such as nicotine replacement therapy (NRT) or buproprion. Family doctors were not viewed as accessible sources of advice on quitting. Health professionals and community members identified common barriers to accessing effective smoking cessation, including: language, religion and culture; negative attitudes to services; and lack of time and resources for professionals to develop necessary skills.

Conclusions: High levels of motivation do not seem to be matched by effective interventions or successful attempts to quit smoking among Bangladeshi and Pakistani adults in the UK. There is a need to adapt and test effective smoking cessation interventions to make them culturally acceptable to ethnic minority communities. UK tobacco control policies need to give special attention to the needs of ethnic minority groups.

Methods
Overview of methods
The methods have been described in some detail.7 Ethical approval was obtained from Newcastle and North Tyneside joint local research ethics committee. We used a community participatory research approach previously developed with ethnic minority communities,12 in which members of the Bangladeshi and Pakistani communities in Newcastle contributed to study development, implementation, and analysis (for details of the Bangladeshi and Pakistani communities in Newcastle, please see box 1 Bush et al). Six male and seven female bilingual community researchers recruited for, and undertook in-depth interviews and focus groups with members of their own communities, usually of the same sex, during 2000–2002. The community researchers translated interview transcripts, where necessary, into English. Around 20% of translated transcripts were sent to an independent translation agency to check consistency. JB interviewed professionals working with the South Asian communities.

Data generation
We completed 12 focus groups (eight groups with men, including mainly smokers and some former smokers; and four groups with female smokers and non-smoking relatives of smokers) and six in-depth interviews with people who felt unable to participate in a group discussion. Participants were
purposively sampled using the same informal recruitment methods used in phase 1 of the research, ensuring approximately equal proportions of Bangladeshis and Pakistanis representing the adult age range. A total of 41 Bangladeshis and 32 Pakistani adults participated (see table 1 below), around half of whom had already participated in phase 1 of the research exploring their attitudes to smoking and health. Eight interviews were conducted with professionals, including three GPs, one practice nurse, two health promotion specialists, one pharmacist, and one community development worker.

**Analysis**

We analysed transcripts to identify recurring, emergent themes using constant comparison of the interview and focus group transcripts, and examination of deviant cases. Fieldwork and analysis continued until no new themes were emerging. JB led the analysis, with the community researchers and members of the research team reading a proportion of transcripts to agree a thematic framework for coding, thus improving reliability. We used NUD*IST 4 textual analysis software to aid analysis. To refine our interpretations, we discussed the analysis at a meeting with local community workers and organisations.

**RESULTS**

Table 1 shows the demographic characteristics and smoking status of all community participants.

### The views of Pakistani and Bangladeshi community members

**Motivation for and barriers to quitting smoking**

Over 60% of male Bangladeshis and Pakistani participants had tried to quit smoking on at least one occasion, mostly aged under 45, and many others said they would like to quit smoking. However, few had been successful and most had relapsed within hours or days (box 1).

One reason for lack of success, particularly in young Bangladeshi men, was pressure from smokers. Stressful events often interrupted cessation attempts, and quitting smoking made it more difficult to cope with stress. Participants also often suffered physical and psychological withdrawal symptoms (box 1).

### Box 1 Experiences of quitting smoking

- Yes I tried [to give up smoking] once and success lasted only two weeks. …friends offered me a cigarette. I took one. I said oh right—I didn’t care (current smoker, focus group of Bangladeshi men, aged 30s–40s, in English).
- I decided that I was not going to smoke. I managed without cigarettes the whole day. But then at the end of the day I would start arguing with the family for one reason or another, and then would start smoking again’ (current non-smoker, interview, Pakistani man, aged 40s, Urdu).
- Three years ago from today I announced amongst my friends that I am quitting cigarettes…. I passed one day. The second day was okay. The third day I felt myself lifeless, that my brain is not working when I was driving. I did not have any sense’ (current smoker, interview, Pakistani man, aged 30s, in Punjabi).
- I stopped for a few days although I felt pain in my body’ (current smoker, focus group of Bangladeshi men, aged 30s, in Sylheti).
- I always think to give up smoking but my bowel does not get clear if I do not smoke just before going into the toilet’ (current smoker, interview, Bangladeshi man, aged 50s–60s, in Sylheti).

### Reasons why participants had not tried to quit smoking

Around 40% of participants, particularly elders, had never tried to quit smoking, although some had considered it (box 2). Participants expressed a range of rationalisation strategies to justify not quitting. Young men who enjoyed smoking when they were socialising felt they were in control of their smoking. Smoking only occasionally, it was not affecting their health to a significant degree, and they would quit in the future. Other smokers drew on examples of friends or relatives who remained healthy despite smoking. Smoking was also viewed as a coping strategy for dealing with everyday stresses, especially among restaurant workers and owners (box 2).

### Reasons for wanting to quit smoking

Most participants gave interrelated explanations for wanting to quit smoking. Health risks associated with smoking were the most commonly cited reason (box 3). Younger male participants described how they wanted to adopt a healthier lifestyle. Participants, or their relatives, who had suffered from an illness perceived to be caused by smoking, had also been motivated to quit. Some participants had stopped smoking on the advice of their doctor, although many of these participants, particularly elders, had failed to act on this advice. Symptoms experienced by participants who smoked were also attributed to smoking, such as difficulty breathing, wheezing, or pain. There were also some concerns about the dangers of passive smoking.

Pressure from family members was another reason for wanting to quit smoking (box 3). In particular, we found that children (especially daughters) would put pressure on their fathers to quit (in households where such pressure was acceptable). Children were reported to be well informed of the risks of smoking. Although there was much peer pressure on men to smoke, male friends would also sometimes exert positive pressure to quit if they were non-smokers, or had previously quit smoking themselves (box 3).
**Box 2 Reasons for not attempting to quit smoking**

‘‘I don’t want to give up. I am happy smoking, and I don’t want to be unhappy’’ (current smoker, interview, Pakistani man, aged 30s, in English).

‘‘Well I think we are all in our forties and I think the majority of us here smoke. It just proves that forty plus people, the majority are on cigarettes and have no intention of kicking the habit’’ (current smoker, focus group of Bangladeshi men, aged 40s, in English).

‘‘Well I would like to say that smoking is a very, very bad habit but I just can’t stop smoking at the minute. I am enjoying myself too much, because of the drink and going out clubbing. And it is like a very big social thing, smoking cigarettes while you are drinking. It blends together one hundred percent. But I will eventually give up definitely’’ (current smoker, focus group of Pakistani men, aged 16–20s, in English).

‘‘The Bangladeshi people living and working in this country, the males smoke more… ninety percent are involved in the catering industry which is very unsociable hours to work. And they have much less time to play’’ (current smoker, focus group of Bangladeshi men, aged 30s–40s, restaurant owners, in English).

Although never cited in isolation, concerns about the cost of cigarettes were often linked to other reasons for wanting to quit. However, others felt that smokers were prepared to buy cigarettes whatever the price (box 4).

While smoking is not explicitly prohibited in the Koran, it is not fully accepted within the Muslim religion. This issue was raised by all age groups but was a particularly strong theme for older participants. Many smokers had cut down or stopped smoking during Ramadan (box 4).

**Experience of informal methods for quitting smoking**

Participants of all ages had tried to quit without using any formal intervention, primarily using willpower. Those who had been successful tended to be admired and respected and were seen to be strong and highly motivated. However, mostly, trying to quit using willpower alone had not been successful (box 5).

Participants also used chewing gum (not NRT) and ate fruit or sweets to keep their mouth occupied. Participants tended to develop their own personal routines that worked for them.

Many male participants had tried to quit during the holy month of Ramadan. However, often they only succeeded in altering the hours during which they smoked or cutting down on cigarettes smoked. Once Ramadan was over, most went back to their usual smoking routine. Some participants had switched to a lower tar cigarette. Some felt that cutting down did not help their health or the addiction (box 5).

**Attitudes to and experience of formal smoking cessation interventions**

Experience of formal interventions was considerably less common than informal approaches. The most commonly experienced intervention was NRT patches, although sprays and gum had also been tried. However, most participants had negative views of NRT, either because they felt it was still putting an addictive substance into the body, or because it had been unsuccessful. NRT was viewed as expensive and requiring willpower to be successful. Few were aware of the evidence for effectiveness of pharmacological interventions or that they could be obtained on NHS prescription. A small number of participants had tried Zyban (Buproprion), though there were fears of publicised side effects (box 6).

Some participants had tried to quit following the advice of a doctor, although many were critical of their GP’s response when they announced they wanted to quit. Some felt their GP was an inappropriate source of advice. Practice nurses were viewed as having a role in supporting smoking cessation, although few participants had received their help (box 6).

**The views of health professionals**

The most common barrier to helping people quit was lack of time; to give advice, counselling and support on smoking cessation was viewed as taking more time than GPs typically have during consultations. It was also felt that many Pakistani and, particularly, Bangladeshi men do not have time to visit their GP for help with quitting. Quitting smoking was also not perceived as a priority for them. While older men were thought to be more willing to try quitting if they had a smoking related condition, young men were seen as less motivated, although this was also viewed as a problem generally with young men (box 7).

Language barriers were often mentioned in relation to smoking cessation. Very few general practices had staff who...
DisCUSSION

Although examples of “good practice” in smoking cessation interventions for UK South Asian communities have been published, there are no published outcome evaluations, and there has been little systematic research on the experiences of community members or professionals on which current tobacco control policy and practice can be based. Our research aimed to help address the latter need by exploring attitudes to smoking cessation among community members and professionals.

This study is not without its limitations; in particular the findings may not be generalisable to other ethnic minority communities. However, it was conducted using a participatory approach and our community participants were broadly representative of the communities from which they were drawn, which have characteristics similar to equivalent ethnic minority communities across the UK.

Three tiers of stop smoking services have been developed throughout primary care in the UK since 1999: brief, opportunistic advice; regular behavioural counselling, with or without drug therapies; and intensive behavioural counselling for individuals or groups, with or without drug therapies. At the time of the fieldwork, a number of bilingual smoking cessation advisors from the South Asian communities were being trained as part of local smoking cessation services. However, we found little evidence that community participants were either aware of or had benefited from these services. In particular, primary care staff seemed unable to take advantage of the training on offer, largely because of time constraints.
In contrast with previous reports on smoking in South Asian communities, attitudes to quitting smoking were found to be typical of the white population in the UK. Religion seemed to affect elders in particular, who expressed less internal control over smoking, citing external forces, such as Allah.

Although most smokers had tried to quit more than once, most had failed. Barriers to success included being tempted by other smokers, work and family stress, and withdrawal symptoms. Similar barriers to smoking cessation have been highlighted in other studies of South Asian communities and the white population.

Our findings on attitudes to smoking cessation among community members extend our findings on cultural understandings of tobacco smoking and provide a detailed account of the barriers to effective smoking cessation perceived by professionals.
Experience of quitting smoking

Methods used to quit smoking by community members focused more on the concept of willpower than has been found in the white population, an approach that is thought to be largely ineffective.20–22 Quit rates were, unsurprisingly, felt to be low.

There was limited experience of using health service interventions. In the general population of the UK, around 40% of smokers seek help or advice from health professionals each year,23 but few community members in this study had sought advice from their general practice. NRT had been used by some participants but, as has been found in studies of both South Asian17 and white populations,24 it was generally viewed as having a low success rate. Hardly any participants had any experience of Bupropion (Zyban), which was felt to be ineffective.21–25 Quit rates were, unsurprisingly, felt to be low.

Motivation to quit among Bangladeshi and Pakistani smokers is thought to be high, but access to services and quit rates are thought to be low.

Implications for policy, practice, and research

Our findings suggest that UK Bangladeshi and Pakistani adults, in particular men, are not currently benefiting from the widespread smoking cessation services that have been implemented across the UK as a part of the national tobacco control strategy since 1999,16 although many of their attitudes to and experiences of quitting show remarkable similarities with those of the general public. With the introduction of the Race Relations (Amendment Act) 200024 public authorities have an obligation to promote racial equality in access to smoking cessation services. Ethnic minority groups (particularly those with high smoking prevalence) should be given greater attention in national tobacco control policies, as have women, the socioeconomically disadvantaged, and children.14

Government, together with health promotion agencies, strategic health authorities, primary care trusts, and local government should work together to develop effective tobacco control policies and interventions for smoking cessation among South Asians, involving south Asian

Policy implications

- Ethnic minority groups (particularly those with high smoking prevalence) should be given special attention in national tobacco control policies, as have women, the socioeconomically disadvantaged and children.
- Governments, together with health promotion agencies, health authorities, and local government should work together to develop effective tobacco control policies and interventions for smoking cessation among ethnic minority groups. Where appropriate, agencies should involve ethnic minority communities in the design, publicity, implementation, and evaluation of such interventions.
- Policies and interventions need to be developed to help health professionals overcome the barriers they experience in communicating with ethnic minority groups, including appropriate interpreting services and training in cultural competency.
- Research policy needs to reflect the needs of ethnic minority groups. For example, smoking cessation interventions of known effectiveness need to be adapted for use with ethnic minorities, based on a detailed understanding of attitudes to smoking and smoking cessation among relevant communities and the professionals who serve them.
communities in their design, publicity, implementation, and evaluation.

More also needs to be done to overcome the barriers experienced by health professionals, in particular those relating to communication with ethnic minority groups. There is significant under-provision of interpreting services currently and norms need to be established for the availability of such services at national and local levels. More training should be available for primary care staff on how to communicate effectively with South Asian people and how effectively to offer effective stop smoking interventions to these groups.

Such developments in practice need to be underpinned by further research, using a staged approach. Firstly, methods to study smoking behaviour in ethnic minority groups need to improve. Secondly, interventions of known effectiveness need to be made more accessible to UK ethnic minorities, based on a detailed understanding of attitudes to smoking and smoking cessation among relevant communities and the professionals who serve them, and then rigorously tested for acceptability, efficacy and effectiveness. A randomised controlled trial of community smoking cessation workers for South Asian men has been funded as a part of the National Prevention Research Initiative in the UK to build on the work reported here.

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CONTRIBUTIONS

MW was principal investigator. JB contributed to the supervision, management and training of the community researchers, design of research materials, data collection, data validation, and took the lead in data analysis and report writing. RB, MW, JK and JR contributed to the study hypothesis, research design, data analysis, research materials and data validation; commenting on drafts of the text; and gained funding for the research. JK and JB designed the training programme. MW drafted this paper. Jane Harland contributed to the research design and funding proposal. All authors are study guarantors. Thirteen community researchers organised, recruited, research design and funding proposal. All authors are study

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